Federation of American Hospitals
Statement for the Record

U.S. House of Representatives
Committee on Ways & Means
Subcommittee on Health

Hearing on Expiring Medicare Provider Payment Policies

Wednesday, September 21, 2011

1100 Longworth House Office Building

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The Federation of American Hospitals (FAH) is pleased to submit the following statement for the record as the U.S. House of Representatives Ways and Means Health Subcommittee considers expiring Medicare provider payment provisions especially critical to our rural hospitals. The FAH is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include general community hospitals and teaching hospitals in urban and rural America as well as inpatient rehabilitation, long term acute care, psychiatric and cancer hospitals.

FAH appreciates the Committee's interest in the impact of these provisions on patients and providers alike. Rural hospitals are the health and economic backbone for communities across America, delivering vital health care to millions of Americans. They are often the sole source of comprehensive health care where they are located, and are typically the largest employer, and economic engine, in the communities they serve.

Especially in our current economic environment, rural hospitals face a wide array of financial difficulties and operational challenges which imperil their ability to continue to serve these areas in the manner that rural citizens expect and deserve. Chief among them is the steady erosion of public funding under Medicare and Medicaid. Extending targeted payment policies that are set to expire is critically important to bolster their fragile finances and help preserve these hospitals so they can continue to meet their mission.

The rural population served by community hospitals is typically older and poorer, which means that rural hospitals are forced to rely to a greater extent on Medicare and Medicaid funding, and are, therefore, especially vulnerable to cuts to these crucial sources of payment. This is particularly troubling because of the well-documented Medicare and Medicaid payment shortfalls. The Medicare Payment Advisory Commission (MedPAC) reports negative 4.9 percent overall Medicare margins for rural hospitals in 2009, the seventh consecutive year that Medicare payments fell below the cost of care. That number is expected to drop further in 2011. Medicaid payment shortfalls are even larger, while mounting state budget deficits are leading to lower payments at the same time that the struggling economy causes Medicaid caseloads to grow.

These payment pressures, combined with the challenges of chronic workforce shortages, relentless regulatory burdens that increase in size and scope, limited access to capital, and the difficulty of a small rural hospital to generate economies of scale, further threaten an already vulnerable, yet vital community asset.

While we welcome the Subcommittee's examination of certain expiring Medicare payment policies, we strongly urge their extension. Below, we discuss specific policies.

- **Low-Volume Hospital Payment Adjustment**

  This provision has its roots in a MedPAC recommendation. It recognizes the fact that rural facilities, which are typically small and more isolated, are handicapped in their ability to drive lower unit costs through greater economies of scale. This sliding-scale payment adjustment helps compensate for this competitive disadvantage.

- **Section 508 Wage Index Reclassification**

  Originally enacted as part of the Medicare Modernization Act, this provision addresses one of many flaws of the current wage index system, and enables certain hospitals to obtain a fair and equitable wage index adjustment that would otherwise be unavailable to them.

  The subject of geographic adjustments to Medicare payments generally, and the wage index in particular, is currently under broad review. Earlier this year, the Centers for Medicare and Medicaid Services (CMS) released a report by one of its contractors, Acumen, that introduced a novel approach to determining wage index adjustments. Later, in June, the Institute of Medicine (IOM) released a study, sponsored by CMS, recommending fundamental structural changes to the wage index methodology including data sources. The IOM expects to release two additional studies addressing geographic adjustments. Also, under the Affordable Care Act, Congress directed CMS to submit a report by the end of this year that includes a plan to reform the hospital wage index system and which takes into account reforms previously recommended by MedPAC.

  We look forward to the completion of these studies so that they can be fully evaluated by Congress in the context of comprehensive wage index reform. In the meantime, Section 508 provides an important avenue for hospitals to receive an appropriate wage index adjustment in a Medicare payment system that is structurally underfunded.

- **Outpatient Hold Harmless for Small Rural Hospitals**

  Since its inception in 2000, the Medicare outpatient prospective payment system (OPPS) has paid hospitals well below the cost of outpatient care. According to MedPAC, in 2009 the margin on Medicare outpatient services was negative 10.8 percent, about the same level it has been since 2003. This is particularly troubling for rural hospitals, as more of their services are provided in the outpatient setting, more services continue to migrate from inpatient to outpatient, and Medicare accounts for a greater percentage of revenue.

Recognizing this vulnerability, Congress has historically provided small rural hospitals with a safety net that partially bridges the gap between pre and post-OPPS payments. These hold-harmless payments have declined over time to 85 percent of the difference, so that even with this protection, Medicare outpatient payments to rural hospitals still fall substantially below the cost of care. As long as this payment shortfall exists, Congress should extend this important payment protection.

- **Medicare Dependent Hospital Program**

  As noted earlier, rural hospitals provide health care to communities that are typically older, and these rural facilities are often their chief source of hospital care. This provision is designed to provide an additional measure of protection for smaller rural hospitals serving a disproportionate Medicare caseload – greater than 60 percent. Because Medicare payments fall so far below the cost of care, and because these small rural hospitals have virtually no other revenue recourse to defray this substantial payment shortfall, Congress since 1987 has provided a modest supplemental payment to help ensure the survival of these hospitals and access to hospital care for seniors in rural communities. We urge Congress to continue this program and reassure seniors that the hospitals they depend on for care will be there when they need them.

- **Physician Pathology Services**

  Independent laboratories have long partnered with rural hospitals to provide essential pathology services for seniors receiving hospital care. In general, the laboratory is paid separately for these services under the Medicare physician fee schedule. In November 1999, however, CMS denied laboratories the ability to bill CMS directly for the technical component of pathology services provided to beneficiaries in a hospital setting, threatening to disrupt this longstanding arrangement and impose a new financial burden on rural hospitals. CMS asserted that the hospital DRG payment already bundled these costs into the payment, an assertion that rural hospitals dispute.

  In response, Congress, in 2000, grandfathered the longstanding practice, permitting independent laboratories with existing hospital arrangements to bill CMS directly for the technical payment component for pathology services provided to seniors receiving hospital care. Congress should continue this sensible solution.

Conclusion

FAH encourages the Members of the Subcommittee to continue their support for the fore mentioned payment policies so critical to rural hospitals. Furthermore, we stand ready to work with Congress to ensure continued access to quality health care for seniors.